DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G072	A. BUILDING _____ B. WING _____	R 04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1318 45TH PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS On April 19, 2007, a follow-up survey was conducted to verify compliance with the Condition of Client Protections previously determined to not be in compliance on March 9, 2007. The findings of the survey were based on observations at the group home and interviews with staff and clients, and the review of records including incident reports and administrative records. Although the facility made some progress, it was determined that the Condition of Participation in Client Protections had not been met.	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body failed to provide general operating direction over outside services: The findings include: 1. The facility's governing body failed to have an effective monitoring system to ensure client safety during transportation, as evidenced by the following: a. On April 19, 2007, at approximately 8:50 AM, clients and staff began loading into a grey Chevrolet Venture minivan that was parked in the driveway. A sticker observed on the Ohio license plate indicated that the registration had expired 10/06. The driver and attendant looked at the	{W 104}		

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 MAY 29 P 4:41

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Amy R Brooks — CEO — 5-29-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 104}	Continued From page 1 license plate and confirmed the expired tag. A direct support staff person overheard the discussion and went back inside the facility. At approximately 8:57, the staff person returned to the vehicle and informed this surveyor that they had a current registration sticker, which they planned to apply to the license plate. At approximately 10:38 AM, the Qualified Mental Retardation Professional (QMRP) stated that he was previously unaware of the expired sticker. The QMRP had begun employment with the facility in December 2006. The Chief Operating Officer (COO) was present at the time of the interview. She stated that the previous QMRP had been given a new registration sticker in October but failed to place it on the license plate, for reasons not known. She indicated that vehicle safety inspections were not required in Ohio and that the facility's "Safety Committee" had recommended (date not indicated) that the agency register all of its vehicles, including the grey minivan, in the District of Columbia. Further interview revealed that the minivan had been in use by the facility for years (length of time not specified) and had been in and out of the repair shop recently, including after two accidents. On April 20, 2007 (post-survey), the QMRP submitted via fax transmittal photocopies of the registration and sticker. Review of the registration revealed "Reg. Date 4/19/07" and "Issue Date 4/19/07." Further review of the registration revealed an odometer reading of 116 miles (presumably a reading taken at the time the vehicle was purchased in Ohio, on 8/4/03). b. On April 19, 2007, at 8:59 AM, Clients #1, #3, #5 and #6 were observed seated in a grey	{W 104}	The registration sticker has placed in the van. On April 19, 2007, a replacement registration sticker was immediately requested by the governing body from the Department of Motor Vehicles (Ohio). A replacement sticker was immediately sent to the governing body to place on the van. The date of the replacement sticker coincides with the date (April 19, 2007), the date the governing body requested the replacement sticker. The odometer reading on registration paperwork was the odometer of the van when it was originally purchased. In the future, the governing body will ensure that the van has an updated registration sticker. Refert to attachment #1	4-19-07 4-19-07

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{W 104}	Continued From page 2 minivan without their seatbelts secured. [Client #4 was buckled in.] At 9:02 AM, a direct support staff person was observed instructing the clients to buckle their seatbelts. Clients #1 and #3 voiced their objections and physically rejected the seatbelts. No additional prompts were given to the clients and at 9:04 AM, the van began backing down the driveway. This surveyor stopped the vehicle and asked to see everyone's seatbelts. Clients #1, #3, #5 and #6 were not secured. The attendant, sitting in the front passenger seat, stated that none of the clients wear seatbelts... "it's like this every morning." This surveyor informed everyone that the law mandates the use of seatbelts for all passengers. The driver and attendant fastened the seatbelts for Clients #1, #3 and #5, without further objections noted from the clients. When asked why Client #6 was still not buckled in, the driver and attendant indicated that there was no seatbelt available where she was seated. When interviewed at 10:37 AM, the QMRP stated that staff had not previously brought this problem to his attention. At 2:25 PM, the minivan returned to the facility with Clients #3, #5 and #6. The driver and attendant said Clients #1 and #4 were still at day program. Clients #3, #5 and #6 were not buckled in. When queried, staff said they had just unbuckled their seatbelts. When asked how they unbuckled Client #5's seatbelt, who was seated in the back seat (2 benches back), they replied that she had unfastened her own belt as they pulled into the driveway. Client #5, who is elderly and had not been receptive to communications with this surveyor earlier in the day, hurriedly got off the minivan and entered the facility.	{W 104}	The safety training goal on (seat belt) was implemented by the Qmrp. The in-service training was completed to ensure each client has a seat with a seat belt. In the future the management team will ensure that all of the clients are buckled up during transportation. Refer to attachment #2 All seat belts were checked by the Facility Coordinator, and the Safety Committee Chairman to ensure that all seatbelts are functional. A checlist form was developped to be used during the Vehicle inspection report. Currently, clients are transported in two different vans to ensure that everyone has a seat belt (Staff and individuals). Refer to attachment #3	4-20-07 4-20-07

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{W 104}	Continued From page 3 2. The governing body failed to ensure an effective system to ensure that agency's incident management policies and procedures were implemented. [See W149, W153 and W154]	{W 104}		
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, it was demonstrated that facility staff (direct care staff and QMRP) failed to ensure that all injuries of unknown origin were reported immediately to the administrator [See W149 and W153]; failed to initiate immediate investigation of injuries of unknown origin [W154]; and the QMRP failed to adequately monitor in-home transportation services to ensure client safety [W104.1 and W159.1]. The findings of these systemic practices results in the facility's continued failure to adequately govern the facility in a manner that would ensure that its clients were protected from injuries and potential harm.	{W 122}	The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner, and that the full investigation is be completed. Both incidents that occurred on that day were fully investigated. In the futue the Qmrp will ensure that all incidents are reported, and he will also adequately monitor the in-home transportation to ensure clients safety. Refer to attachment #4 Refer to attachment #2 P. 3	4-20-07
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation and interview, facility staff failed to implement its policy and procedures of	{W 149}		

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{W 149}	Continued From page 4 notifying its incident management coordinator and designated administrator of injuries of unknown origin. The finding includes: Cross-refer to W153. On April 19, 2007, Client #4 showed this surveyor bruises on both her right and left arms. Two direct support staff who observed the bruises that morning failed to bring the bruises to the attention of the medication nurse, Designated Nurse, House Manager or the QMRP before the end of their shift, in accordance with facility policies. The QMRP was informed of the bruises at approximately 3:15 PM. The QMRP then left the facility at approximately 4:51 PM without asking the nurse to assess the client's arms or completing an incident report form, in accordance with facility policies. Telephone interview with the incident management coordinator at 5:12 PM revealed that neither she nor the designated administrator were aware of bruises of unknown origin on Client #4, more than 10 hours after staff had first observed the bruises. It should be noted that direct care staff thought the bruises were self-inflicted, due to "pinching." The client's psychological assessment and behavior support plan, however, did not include "pinching" as a target behavior. Later in the day, the QMRP and the Designated Nurse LPN both indicated that they too thought the bruises might be due to a target behavior. Review of the behavior plan revealed that she was known to pick at her fingers and at scabs or excoriated	{W 149}	The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner, and that the full investigation is be completed. Both incidents that occurred on that day were fully investigated. In the futute the Qmrp will ensure that all incidents are reported, and he will also adequately monitor the in-home transportation to ensure clients safety. Refer to attachment #4 Refer to attachment #2 P. 3 The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. Refert to attachment #4 . The Behavior Specialist inserviced on client #4 BSP, including the proper documentation, and data collection. The 3rd quarterly addresses the issue of pinching herself, and the addendum was completed.	4-20-07 4-20-07 5-16-07 4-28-07.

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{W 149}	Continued From page 5 areas on her arms and neck.	{W 149}		
{W 153}	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to report all injuries of unknown origin immediately to the administrator, for one of the five clients residing in the facility. (Client #1) The finding includes: On April 19, 2007, Client #4 greeted this surveyor upon entry to the facility, at 6:57 AM. She pointed to a bruise on her upper left outer arm. The bruise was a dark brown with greenish-yellow tint around the outside. A direct support staff person (S1) stated that the client pinches herself. At 7:11 AM, another direct support staff person (S2) entered the room and when the client pointed at the bruise, the staff asked her "did you do that?" "How did you do that?" The client was non-verbal but pointed again at the bruise. The staff then told her "we'll have to show that to the nurse." The morning medication nurse arrived at approximately 7:25 AM. At 8:28 AM, Client #4 showed this surveyor a brownish-green bruise on her upper right arm while seated in the living room. The Designated Nurse arrived to the facility at approximately the same time. Five of	{W 153}	The Behavior Specialist inserviced on client #4 BSP, including the proper documentation. 5-16-07 The 3rd quarterly addresses the issue of pinching herself, and the addendum was completed. 4-28-07. Refer to attachment # 5	

[redacted]

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{W 153}	Continued From page 6 the six clients left for day program at approximately 8:50 AM. At 9:20 AM, the House Manager answered "no" when asked if anyone had sustained bruises or cuts during the past few days. [It should be noted that she was aware that a client had fallen that morning in the bathroom.] At approximately 9:48 AM, the medication nurse indicated she was leaving the facility. When asked, she said Client #4 was "fine" and had not sustained any bruises in recent days. The Designated Nurse was present during the conversation. When asked at approximately 9:55 AM, the Designated Nurse stated that Client #4 had pulled her toenail off approximately one month before. One of the client's target behaviors in her behavior support plan (BSP) was "picking her skin and nails." At 11:08 AM, the QMRP confirmed this and presented the BSP (dated July 2006) and data sheets. At 2:51 PM, the QMRP said there had been no unexplained bruises reported in recent days. Review of Client #4's nursing progress notes (filed in the Medication Administration Record binder) revealed no mention of bruises. The QMRP presented the client's psychological assessment, dated July 2006, that addressed her picking at "cuticles, fingers... scabs and excoriated areas on her arms and neck." There was no evidence, however, that she would pinch herself or otherwise cause bruising to her arms. The QMRP agreed that the words "pinch" and "pick" describe two different behaviors. Further review of Client #4's behavior data sheets revealed that she had picked at herself; however, there were no incidents of pinching documented. At approximately 3:15 PM, this surveyor read to the QMRP his observation and interview notes	{W 153}	The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensur that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. The Behavior Specialist inserviced on client #4 BSP, including the proper documentation. 3rd quarterly addresses the issue of pinching herself, and the addendum was completed. Refer to attachment # 5	4-20-07 5-16-07 The 4-28-07.

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{W 153}	Continued From page 7 from the morning shift. He indicated that he was previously unaware of any bruises on Client #4. The QMRP was about to leave the facility at approximately 4:50 PM. When asked, he indicated that there was no incident report prepared thus far for Client #4's bruises of unknown origin. At 5:12 PM, interview by telephone with the facility's Incident Management Coordinator revealed that she was previously unaware that Client #4 had bruises on her arms, or that Client #6 had fallen in the bathroom at 6:00 AM that morning. The facility's incident management policies require that upon discovery, direct support staff should bring injuries of unknown origin to the attention of the House Manager, QMRP and/or nurses before the end of their shift. While Client #6 had been assessed that morning after the fall, Client #4's bruises were not assessed by nursing staff until 5:30 PM, when this surveyor brought it to the attention of a Quality Assurance officer who was on-site that evening.	{W 153}	Refer to W 153 P. 7	4-20-07 & 5-15-07
{W 154}	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to promptly investigate injuries of unknown origin (bruises) observed on Client #4. The finding includes:	{W 154}		

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{W 154}	Continued From page 8 Cross-refer to W153. On April 19, 2007, Client #4 pointed to a bruise on her left arm. A direct support staff person (S1) stated that the client pinches herself. At 7:11 AM, another direct support staff person (S2) entered the room and saw the bruise. At 8:28 AM, Client #4 showed this surveyor another bruise on her right arm. The morning medication nurse was in the facility between 7:25 AM - 9:48 AM. Direct support staff from the morning shift failed to bring the bruises to the attention of the medication nurse, Designated Nurse, House Manager or the QMRP. Review of Client #4's psychological assessment and BSP, both dated July 2006, revealed a target behavior of picking at "cuticles, fingers... scabs and excoriated areas on her arms and neck." At approximately 3:15 PM, the QMRP was informed of the bruises. At 5:12 PM, the facility's Incident Management Coordinator stated over the telephone that she was unaware of Client #4's bruising. At approximately 5:30 PM, the Designated Nurse asked if incident reports were required when a client has a known target behavior. The Designated Nurse agreed that there is a difference between picking at scars/excoriated areas versus pinching oneself to cause a bruise. He proceeded to assess Client #4's bruised arms and the Quality Assurance officer (who was on-site that evening) initiated an investigation, more than ten hours after staff first observed the bruises.	{W 154}	Refer to W 153 P 7 Refer to W 153 P 7	4-20-07 & 5-15-07 4-20-07 & 5-15-07
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	{W 159}		

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{W 159}	Continued From page 9 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety. The findings include: 1. Cross-refer to W104.1. The QMRP failed to monitor the transportation services provided for the six clients residing in the facility. Direct support staff indicated that clients refused to use seatbelts every morning en route to their day programs. The minivan used by the facility had expired tags (since October 2006). When he was interviewed on April 19, 2007, beginning at 10:37 AM, the QMRP stated that he was previously unaware of either of the two concerns. 2. Cross-refer to W192. The QMRP failed to ensure that direct support staff received training as indicated for Client #2's bathing needs, as outlined in a March 1, 2007 health maintenance care plan update. When interviewed, the QMRP indicated that he had not verified the staff had received training. 3. Cross-refer to W436. The QMRP failed to monitor Client #6's physical therapy needs, to ensure that she received a dynamic ankle foot orthosis for her right ankle, as recommended by the Physical Therapist on August 14, 2006.	{W 159}	Refer to W 104 P. 2, & P. 3	4-19-07 & 4-20-07
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training	W 192	An update in-service for bathing male and female client was completed with special emphasis on client #2 HMCP. In the future, the nurse the nurse will immediately in-service the staff as soon as the HMCP is revised. The ankle orthosis for client # 6 has been ordered on 5-23-07 from AliMeds Inc. The comfirmation # is G5004. In the future, the LPN will ensure that the PT recommendations are followed on the timely manner.	5-16-06 6-01-07

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W 192	Continued From page 10 must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: On April 19, 2007, the facility failed to show evidence that direct support staff who assisted Client #2 with bathing had received training on methods to prevent urinary tract infections. The finding includes: Cross-refer to W331.3. On April 19, 2007, at approximately 9:23 AM, the Designated Nurse LPN stated that Client #2 was seen by his primary care physician (PCP) on the day before (4/18/07) and began receiving Amoxicillin that evening. According to the LPN, the PCP had evaluated the client on April 11, 2007 and diagnosed a urinary tract infection (URI). Client #2 reportedly had recurrent UTIs. A March 1, 2007 update to Client #2's Health Management Care Plan included the following procedure: "Gently pull the foreskin of the penis back and wash it and the head." This was assigned to direct care staff, who according to the care plan required training. At 4:01 PM, the LPN was asked whether staff had been training on assisting the client while bathing (specifically the need to clean under the foreskin). The LPN reported that he had conducted "Infection Control" training, to include that topic, on January 5, 2007. However, he was unable to locate staff sign-in sheets and/or the agenda of topics covered; therefore the purported training could not be verified.	W 192	An inservice on UTI was completed by the LPN. In the future the LPN will train the staff on the health management care plan each time it revised, and updated. Refer to attachement #6	5-16-07
{W 322}	483.460(a)(3) PHYSICIAN SERVICES	{W 322}		

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{W 322}	Continued From page 11 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure general and preventive care for two of the six clients residing in the facility. (Client #2 and #6) The findings include: 1. Cross-refer to W436. On April 19, 2007, direct care staff and the medication nurse reported that Client #6 had fallen that morning in the bathroom. The client was observed that morning walking with an unsteady gait, using furniture and the walls for balance as she moved from room to room. Review of the client's Physical Therapy assessment, dated August 14, 2006, revealed that she was to use a "dynamic ankle foot orthosis for her right ankle." There was no evidence, however, that the facility's medical team ensured that Client #6 received a dynamic ankle foot orthosis for her ankle in the 10 months since she was assessed. 2. Cross-refer to W331.3 On April 19, 2007, the Designated Nurse LPN reported that Client #2 was being receiving Amoxicillin for treatment of a urinary tract infection (UTI). The client reportedly had a history of UTIs. The facility failed to document implementation of the client's March 1, 2007 care plan to address urology. There was no evidence that direct care staff had been trained on the care plan update (which included specific interventions to be used during bathing), or that the medical team was monitoring the	{W 322}	The ankle orthosis for client #6 has been ordered on 5-23-07 from AliMeds Inc. The comfirmation # is G5004. In the future, the LPN will ensure that the PT recommendations are followed on the timely manner.	6-01-07
			An inservice on UTI was completed by the LPN. In the future the LPN will train the staff on the health management care plan each time it revised, and updated. The RN will monitor the implementation of the HMCP. Refer to attanchement #6	5-16-07

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{W 322}	Continued From page 12 implementation of the care plan.	{W 322}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide each client with nursing services in accordance with their needs. The findings include: 1. The facility's nursing staff failed to ensure that Client #6 received a dynamic ankle foot orthosis for her right ankle, as recommended by the Physical Therapist on August 14, 2006. [See W436] 2. In response to the March 9, 2007 recertification survey (W371), the facility submitted a Self-Medication Assessment for Client #2 as an attachment to the Plan of Correction. On April 19, 2007, at approximately 1:00 PM, review of the self-med assessment, however, revealed a date and signature that was contradicted by interview with the Designated Nurse LPN. The assessment had the current Designated Nurse LPN's signature and was dated August 26, 2006. At 1:09 PM, interview with the LPN revealed that he began employment in the facility in November 2006. When asked about the August 2006 date, there was no response. The assessment's authenticity could not be validated at that time. It should be noted that there was no documented evidence that the August 26, 2006 self-medication assessment (Client #2) had been reviewed by a Registered Nurse, as required.	{W 331}	The ankle orthosis for client #6 has been ordered on 5-23-07 from AliMeds Inc. The comfirmation # is G5004. In the future, the LPN will ensure that the PT recommendations are followed on the timely manner. Thet Self medication Assessment was written by the former designated nurse, and revised by the current LPN;however, he failed to write the date of revision on the assessment. In the future the LPN will write, and sign the date the Self Medication Assessment was revised. (Ex evaluation date 8-26-06 revised 4-20-07).	6-01-07 4-20-07

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{W 331}	Continued From page 13 3. On April 19, 2007, at approximately 9:23 AM, the Designated Nurse LPN stated that Client #2 was seen by his primary care physician (PCP) on the day before (4/18/07) and began receiving Amoxicillin that evening. According to the LPN, the PCP had evaluated the client on April 11, 2007 and diagnosed a urinary tract infection (URI). Client #2 reportedly had recurrent UTIs. When asked if the client wears protective undergarments, the LPN responded "only when he is incontinent." The LPN did not believe that the client had worn protective undergarments since November 2006, when the LPN began employment in the facility. Further interview with the LPN, at approximately 9:46 AM, revealed that Client #2 received Lactulose daily for treatment of chronic constipation. At 9:52 AM, the Designated Nurse LPN presented Client #2's bowel movement chart. At 10:00 AM, review of the Health Management Care Plan, dated August 17, 2006, that was in the client's medical book revealed no mention of UTIs or constipation as "Risk Area or Condition." When asked about the omission, the LPN went into the nurse office. He returned 15 minutes later with an updated care plan sheet that was dated March 1, 2007; it addressed urology. The LPN stated that he had found it filed in the ISP book. At 11:11 AM, the LPN presented another update sheet; this one was dated April 1, 2007 and addressed constipation. Review of the two care plan updates revealed the LPN's signature on each. When asked, the LPN stated "I do care plans" and he had received training via MRDDA (now DDS). Neither the March 1, 2007 or April 1, 2007 update showed evidence that the RN had reviewed the care plan updates, as required.	{W 331}	As per Physicain Order client # wears undergarment as needed. Refer to attachment #7 The HMCP has been revised by the RN to include constipation and UTI. In the future, the nursing services will ensure that all of HMCP include all of the new diagnoses, and that they are written, updated, and sign by the RN. Attachment # 8	5-10-07

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{W 331}	Continued From page 14 It should be further noted that the two updates were not formatted in the same manner as the clients' other care plans, which made it difficult to review. The sheets used the Portrait format whereas other care plans were printed using the Landscape format. The LPN stated that he was unfamiliar with the computer program. It should be further noted that the March 1, 2007 update included the following procedure: "Gently pull the foreskin of the penis back and wash it and the head." This was assigned to direct care staff, who according to the care plan required training. At 4:01 PM, the LPN was asked whether staff had been trained on assisting the client while bathing (specifically the need to clean under the foreskin). The LPN reported that he had conducted "Infection Control" training, to include that topic, on January 5, 2007. However, he was unable to locate staff sign-in sheets and/or the agenda of topics covered; therefore the purported training could not be verified. There was no evidence that the Rgistered Nurse had monitored the implementation of Client #2's health management care plan.	{W 331}	An inservice on UTI was completed by the LPN. In the future the LPN will train the staff on the health management care plan each time it revised, and updated. The RN will monitor the implementation of the HMCP. Refer to attanchement #6	5-16-07
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record	{W 436}		

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{W 436}	Continued From page 15 review, the facility failed to maintain adaptive equipment in good repair for one of the six clients residing in the facility. (Client #6) The finding includes: Observations on April 19, 2007 revealed that Client #6 walked with an unsteady gait. She leaned forward while ambulating, touching furniture and walls as she passed from room to room. This was observed at 7:42 AM as she walked from the dining room to a "favorite" chair located next to a living room window. At 8:22 AM, she walked from the living room to the nurse's office and then to the restroom with great hesitancy and care, using furniture and walls for support. Staff reported that she had fallen earlier that morning (approximately 6:00 AM) while using the bathroom. At 3:22 PM, interview with the QMRP revealed that Client #6 was not prescribed assistive devices for ambulation (walker, wheelchair, etc.). Review of the Physical Therapy assessment, dated August 14, 2006, revealed that she was prescribed balance exercises. The PT had observed her using furniture and walls for balance and he documented that she "will not use an assistive device," except for a "wheelchair for extended outings and doctor's appointments." Further review of the PT assessment revealed the following recommendation: "purchase a dynamic ankle foot orthosis for her right ankle. See picture." At approximately 3:30 PM, the QMRP and Designated Nurse LPN stated that Client #6 remained without the "dynamic ankle foot orthosis" for her ankle. The LPN said he "just	{W 436}	The ankle orthosis for client #6 has been ordered on 5-23-07 from AliMeds Inc. The comfirmation # is G5004.. In the future, the LPN will ensure that the PT recommendations are followed on the timely manner. The ankle orthosis for client #6 has been ordered on 5-23-07 from AliMeds Inc. The comfirmation # is G5004. In the future, the LPN will ensure that the PT recommendations are followed on the timely manner.	6-01-07 6-01-07

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{W 436}	Continued From page 16 saw this last week." He reported having placed a telephone order with the supplier and he expected the item to be delivered "next week." Further review of Client #6's record failed to show evidence of the telephone order made on her behalf. At 3:36 PM, the LPN acknowledged that he failed to document his actions anywhere, for tracking or verification purposes. At the time of the survey, there was no documented evidence that the facility had purchased a dynamic ankle foot orthosis for Client #6's right ankle. It should be noted that the PT recommendation was made in August 2006, eight months before this follow-up visit. This is a repeat deficiency. See Federal Deficiency Report dated 3/9/07.	{W 436}	The LPN placed a telephone order, and failed to document it on the client's progress note. In the future, the nurse will ensure that all telephone orders are documented, and availble upon request. The ankle orthosis for client #6 has been ordered on 5-23-07 from AliMeds Inc. The comfirmation # is G5004. In the future, the LPN will ensure that the PT recommendations are followed on the timely manner.	4-23-07 6-01-07

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{I 000}	INITIAL COMMENTS On April 19, 2007, a follow-up survey was conducted to verify abatement of deficiencies previously identified during the March 9, 2007 licensure survey. The findings of the survey were based on observations at the group home and interviews with staff and residents, and the review of records including incident reports and administrative records. Although the facility made some progress, it was determined that some deficient practices remained unabated, as evidenced in the report that follows.	{I 000}		
{I 206}	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The findings include: On April 19, 2007, review of health certificates submitted following the March 9, 2007 recertification survey revealed continued failure by the GHMRP to show evidence of current health certification for the following:	{I 206}		

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{I 206}	Continued From page 1 - one direct care staff [redacted]; - the House Manager [redacted]; - one nurse consultant [redacted]; - the Pharmacist; - the PT; - the Nutritionist; - the Speech and Language Therapist; and the - Psychology Assisitant.	{I 206}	The health certificates of the following are on file: House manager (redacted), Pharmacist, PT Psychological Assistant. The nurse (redacted) is no longer employed by RCM.	5-30-07
{I 379}	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	{I 379}	The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. Refer to attachment #4	4-20-07
	This Statute is not met as evidenced by: Based on observation, interview and record review, GHMRP direct support staff and the Qualified Mental Retardation Professional (QMRP) failed to implement the facility's incident management policies as written. The finding includes: On April 19, 2007, Resident #4 greeted this surveyor upon entry to the facility, at 6:57 AM. She pointed to a bruise on her upper left outer arm. The bruise was a dark brown with greenish-yellow tint around the outside. A direct support staff person (S1) stated that the client pinches herself. At 7:11 AM, another direct		The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. Refert to attachment #4	4-20-07

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(I 379)	Continued From page 2 support staff person (S2) entered the room and when the client pointed at the bruise, the staff asked her "did you do that?" "How did you do that?" The client was non-verbal but pointed again at the bruise. The staff then told her "we'll have to show that to the nurse." The morning medication nurse arrived at approximately 7:25 AM. At 8:28 AM, Resident #4 showed this surveyor a brownish-green bruise on her upper right arm while seated in the living room. The Designated Nurse arrived to the facility at approximately the same time. Five of the six residents left for day program at approximately 8:50 AM. At 9:20 AM, the House Manager answered "no" when asked if anyone had sustained bruises or cuts during the past few days. [It should be noted that she was aware that a resident had fallen that morning in the bathroom.] At approximately 9:48 AM, the medication nurse indicated she was leaving the facility. When asked, she said Resident #4 was "fine" and had not sustained any bruises in recent days. The Designated Nurse was present during the conversation. When asked at approximately 9:55 AM, the Designated Nurse stated that Resident #4 had pulled her toenail off approximately one month before. One of the resident's target behaviors in her behavior support plan (BSP) was "picking her skin and nails." At 11:08 AM, the QMRP confirmed this and presented the BSP (dated July 2006) and data sheets. At 2:51 PM, the QMRP said there had been no unexplained bruises reported in recent days. Review of Resident #4's nursing progress notes (filed in the Medication Administration Record binder) revealed no mention of bruises. The	(I 379)	The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. Refert to attachment #4 The Behavior Specialist Inserviced on client #4 BSP, including the proper documentation. 3rd quarterly addresses the issue of pinching herself, and the addendum was completed. Refer to attachment # 5	4-20-07 5-16-07 The 4-28-07.

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(I 379)	Continued From page 3 QMRP presented the resident's psychological assessment, dated July 2006, that addressed her picking at "cuticles, fingers... scabs and excoriated areas on her arms and neck." There was no evidence, however, that she would pinch herself or otherwise cause bruising to her arms. The QMRP agreed that the words "pinch" and "pick" describe two different behaviors. Further review of Resident #4's behavior data sheets revealed that she had picked at herself; however, there were no incidents of pinching documented. At approximately 3:15 PM, this surveyor read to the QMRP his observation and interview notes from the morning shift. He indicated that he was previously unaware of any bruises on Resident #4. The QMRP was about to leave the facility at approximately 4:50 PM. When asked, he indicated that there was no incident report prepared thus far for Resident #4's bruises of unknown origin. At 5:12 PM, interview by telephone with the facility's Incident Management Coordinator revealed that she was previously unaware that Resident #4 had bruises on her arms, or that Resident #6 had fallen in the bathroom at approximately 6:00 AM that morning. The facility's incident management policies require that upon discovery, direct support staff should bring injuries of unknown origin to the attention of the House Manager, QMRP and/or nurses before the end of their shift. While Resident #6 had been assessed that morning after the fall, Resident #4's bruises were not assessed by nursing staff until 5:30 PM, when this surveyor brought it to the attention of a Quality Assurance officer who was on-site that evening.	(I 379)	The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. Refert to attachment #4 The Behavior Specialist inserviced on client #4 BSP, including the proper documentation. The 3rd quarterly addresses the issue of pinching herself. Refer to attachment # 5 The Qmrp, the nurse as well as the staff were in-serviced on the incident management. In the future, the Qmrp will ensure that all incidents (known and unknown origin) are reported on the timely manner to the appropriate parties. Refert to attachment #4 The Behavior Specialist inserviced on client #4 BSP, including the proper documentation. The 3rd quarterly addresses the issue of pinching herself.	4-20-07 5-16-07 The 4-28-07. 4-20-07 5-16-07 4-28-07.

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(I 399)	Continued From page 4	(I 399)		
(I 399)	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: On April 19, 2007, review of professional licenses and certifications submitted following the March 9, 2007 recertification survey revealed continued failure by the GHMRP to show evidence of current ASHA (American Speech Language Hearing Assoc.) certification on file at the time of the survey. It should be noted that Resident #2 was recommended Speech Language services, however, this service had not been implemented at the time of survey.	(I 399)		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide treatment	I 422	The Speech and Language Assessment was completed by the speech pathologist on 4-01-07.	

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I 422	Continued From page 5 and services in accordance with two of the six residents' Individual Habilitation Plans. (Resident #2 and #6) The findings include: See Federal Deficiency Report - Citations W322, W331 and W436	I 422		